DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 10 -- 0 3 6

2. STATE: **COLORADO**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2010

5. TYPE OF PLAN MATERIAL *(Check One)*:

NEW STATE PLAN | AMENDMENT TO BE CONSIDERED AS A NEW PLAN | **X AMENDMENT**

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION
42 C.F.R. 460.182

7. FEDERAL BUDGET IMPACT
a. FFY 09-10 $ 0
b. FFY 10-11 $ 0
c. FFY 11-12 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment Page 1, Supplement 3 to Attachment 3.1-A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment Page 1, Supplement 3 to Attachment 3.1-A ~~Attachment Page 2,~~ " "

10. SUBJECT OF AMENDMENT
Clarification regarding PACE reimbursement methodology

11. GOVERNOR'S REVIEW *(Check One)*

GOVERNOR'S OFFICE REPORTED NO COMMENT | **X OTHER, AS SPECIFIED**

Governor's letter dated 26 ~~January~~ 2009 7/29/09

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL

16. RETURN TO

13. TYPED NAME
Bob Douglas

14. TITLE
Director, Legal Division

15. DATE SUBMITTED
September 24, 2010

Colorado Department of Health Care Policy and Financing
1570 Grant Street
Denver, CO 80203-1818

Attn: Barbara Prehmus

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED 9/24/10

18. DATE APPROVED 12/16/10

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
7/1/10

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
Richard C. Allen

22. TITLE
ARA, DMCHO

23. REMARKS

Attachment Page 1 to State Plan Enclosure 7, page 7

IV. Rates and Payments

Rates for the PACE program are established by calculating a historical per member per month amount for a PACE comparable set of fee-for-service member months. That historical per member per month (PMPM) comparison is then adjusted, on a service category specific basis, to account for expected changes in price and utilization between the historical period and the future rate effective period.

Benefits under risk for the PACE program include all state plan services. Therefore, the above referenced PMPM figure includes consideration of all services paid on behalf of the fee-for-service comparison population, including all claims in the Medicaid Management Information System that were provided on behalf of the fee-for-service comparison population during the member months of eligibility for that population.

The fee-for-service member months that are considered in PACE rate setting include all months where Medicaid eligibles could have potentially been PACE eligible, but were fee-for-service recipients instead. Therefore the member months considered in rate setting exclude individuals under 55 years of age, exclude those who are not long-term care recipients, and include only fully eligible Medicaid eligibles, such as QMB plus and SLMB plus dual eligibles.

PMPM calculations are equal to state plan services cost incurred during the comparison fee-for-service member months divided by the number of those member months. No lump sum supplemental payments made to providers outside of fee-for-service shall be considered when determining the PMPM calculations. The PMPM calculations are segregated into rate cells. Rate cell assignment is based upon factors such as age, eligibility category, Medicaid/Medicare dual eligibility, and the presence of other third party insurance. The PMPM calculations are further separated based on the Nursing Facility (NF) and Home and Community Based Services (HCBS) populations. An incurred but not paid (IBNP) analysis is used to create a claims completion factor.

The completed historical NF and HCBS PMPMs are adjusted to the rate effective period by applying a trend. That trend is calculated to consider both utilization and changes in unit cost. Data used to calculate the trend includes primarily historical PMPM changes observed in the fee-for-service PACE comparison population but also may include observations of other state Medicaid data, commercial data or industry-wide experience.

The NF and HCBS PMPM calculations are made on a statewide basis to pool as much claims experience as possible for data smoothing purposes. That statewide calculation is adjusted by factors designed to measure the differences in cost between different regions of the state. Those factors are equal to a ratio that is regional specific PMPM average costs divided by statewide average PMPM cost. After the regional adjustment has been applied to the NF and HCBS PMPMs, they are blended together into one PMPM for each rate cell using a frailty factor.

Attachment Page 2 to State Plan Enclosure 7, page 7

Entry Point Agency. Clients who are already Medicaid eligible need not apply for eligibility.

B. Enrollee Information

Once enrolled, the individual is provided the following:

- A copy of the Enrollment Agreement, which includes complete information regarding PACE, as well as the Participant's Bill of Rights;
- A membership card;
- Self-adhesive informational emergency stickers that can be posted in the individual's home, explaining how to access emergency care;
- The Medicaid card is printed with the name of the provider;
- A copy of the plan of care;
- A list of the provider's employees who provide care and a current list of contracted providers.

C. Disenrollment Process

Voluntary Disenrollment

A participant may voluntarily disenroll for any cause at any time; however, 30 days notice is required in order to reinstate the individual in the Medicare and Medicaid fee-for-service systems. The participant and/or family or other representatives will meet with social work to discuss the reason for the disenrollment and explain the procedure. If the reason is dissatisfaction, a grievance form will be completed and resolution attempted prior to the disenrollment. A copy will be provided to internal quality management and the state Medicaid agency. Information will be provided to the disenrolling participant to assure services can be readily accessed in the fee-for-service systems.

Involuntary Disenrollment

A participant may be disenrolled if she/he:

1. Moves outside the provider's service area;
2. Becomes ineligible for Medicaid and is unable or unwilling to pay PACE organization privately;
3. Fails to pay or make satisfactory arrangements to pay any amount due the provider, after a 30-day grace period;
4. Is outside the provider's service area for more than 30 days without prior arrangements;
5. Is enrolled in a program that loses its contract and/or licenses;
6. Engages in disruptive or threatening behavior that jeopardizes the health or safety of him/herself or others, or, when a participant with decision-making ability refuses to comply with the plan of care or terms of the PACE agreement;
7. Is determined to no longer meet the nursing home level of care requirements;